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ABSTRACT

Presented are proceedings from a 3-day study institute (1971) to provide teachers of mentally handicapped (MH) students, health profession personnel, and physical education teachers in Schenectady with resource information for implementation of New York state's mandate to provide health education for all children. Included are the program schedule and a review of institute purposes which stresses the need to cope with increasing drug abuse. The following presentations are discussed: the role of the community resources in health education and reeducation; broad aspects of health education for MH students; and an outline to health education for MH children in elementary and secondary schools which includes components such as physical fitness, testing, and program content. Also given are guidelines for teaching physical fitness to MH children; a discussion on the role of the nurse-special teacher in health which involves aspects such as cooperating with parents and medical professionals to meet MH children's needs; guidelines for teaching concepts of nutrition and consideration of effects of poor nutrition on mental retardation and on the productivity of children; and contributions of home economics educators such as use of the Future Homemakers of America to enrich classroom learning. Included are comments from discussion periods, representative sample evaluation forms, reactions to each session, and comprehensive evaluation which indicates favorable responses to aspects such as content, organization, and practicability for classroom instruction. (MC)

"HAPPINESS IS HEALTHINESS"

ED 093127

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THE STATE EDUCATION DEPARTMENT
BUREAU FOR MENTALLY HANDICAPPED

in cooperation with

THE CITY SCHOOL DISTRICT OF
THE CITY OF SCHENECTADY

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Present Conference Highlights

A Special Study Institute in
Health Education for Mentally
Handicapped Children in Elementary
and Secondary Schools

May 12, 13, 14, 1971

Paige School

Schenectady, New York

Special Studies Institute
Funded through P.L.
91 - 230, as amended
U.S. Office of Education

EC062248

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FOREWORD

This publication summarizes the Proceedings of the Special Study Institute held at Paige School, Schenectady - May 12-14, 1971, under the sponsorship of the Division for Handicapped Children, Bureau for Mentally Handicapped Children, New York State Education Department, and the Schenectady City School District. The Institute was funded through P.L. 85-926, as amended, United States Office of Education.

The purpose of this Institute was to bring together special class teachers of the mentally handicapped, school-nurse teachers, health personnel, selected supervisors and representatives from pupil-personnel services and physical education staff who work with mentally handicapped children, for the purpose of providing them with resource and background information to help implement the State's mandate for health education to all children.

To fulfill this purpose, selected consultants from various colleges and universities and State Department Units presented and reviewed the knowledge and materials available in the field of health education which could be useful with the mentally handicapped. The content represented in these proceedings includes much of the discussions and some of the resource materials that were made available to the participants.

The participants representing city, and selected Board of Cooperative Educational Services personnel were most interested and evaluated most sessions accordingly. The composite evaluation is included in this report.

This publication should serve as a further stimulus and motivator, to all who participated and those who read it to use the contents for resourceful application of health education for mentally handicapped children.

ACKNOWLEDGMENT

The contents of this proceedings represent the efforts of all persons named in its pages.

Special acknowledgments go to (1) Mr. Salvatore Tavormina, who helped with the necessary finding and advising in the planning of the institute and in the preparation of the proceedings, (2) to Dr. Ronald Ross for his advice, (3) to Dr. Bruce Brummitt for making it possible for wide staff participation and making available excellent facilities for this study institute, (4) to Mr. Francis Willette for assisting with local coordination, (5) to Miss Sue Gallo, Principal at Paige School and her staff, and (6) to the Schenectady City School District and New York State Department members of the planning committee.

Gratitude is also tendered to the institute speakers and consultants who made available their speeches and presentations for purposes of publishing this report.

Finally, appreciation is extended to Dr. Anthony J. Pelone and Mr. Raphael F. Simches of the Division for Handicapped Children, New York State Education Department.

Jayne B. Rycheck
Institute Director
Schenectady City School District

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Program Schedule

Wednesday, May 12, 1971

Paige School, Elliott Avenue at Consaul Road, Schenectady, New York

1:00 - 1:30 p.m.	Registration
1:30 - 4:30 p.m.	General Opening Session Auditorium

Theme - Happiness Is Healthiness

Greetings

Dr. Bruce Brummitt - Superintendent of Schools City School District of the City of Schenectady, New York

Overview

Mr. Salvatore Tavormina, Associate in Bureau for Mentally Handicapped, Division for Handicapped Children
New York State Education Department

Health Education Curriculum

Sociological and Environmental Aspects

Dr. Gordon Bianchi, Coordinator Health Education Project
Institute Materials Center
State University College at Buffalo, New York

Miss Sarah Dunne, Special Project Coordinator - Unit on Drugs and Health Education

Mr. Thomas Claybock, Institute Materials Center
State University at Buffalo

Successful Experimentation

Personal and Physical Health

Mrs. Joanne Scullie, Supervisor Division of Health and Physical Education, State Education Department

Special Educators from Schenectady City School District
Special Education Department

Mrs. Rosalie Bradt, Lincoln School - EMR - Primary

Miss Judith Kiernan, Steinmetz School - EMR - Junior High School

Miss Helen Halloran, Linton High School - EMR - Senior High School

Mrs. Eleanor Loomis, Mont Pleasant High School - EMR - Senior High School

Mrs. Elizabeth Pilarski, Brandywine School - EMR - Younger Children

Mrs. Yvonne Durland, Hamilton School - TMR - Older Children

Mr. Gordon Jenkins, Grout Park School - U/H - Elementary

4:30 - 6:30 Dinner

6:30 - 9:30 Open Evening Session to include Mohawk Council for Exceptional Children

Community Resources in Health Education and Reeducation

Exhibits and Materials Display

Mrs. Karen White, Senior Recreation Therapist, Wilton State School

Mr. Oscar E. Carter, Director of Education, Tryon School for Boys, Johnstown, New York

Mr. Walter Silver, Associate Narcotic Education, Narcotic Addiction Control Commission

Thursday, May 13, 1971

8:30 - 9:00 Registration

9:00 - 11:30 General Session

Broad Aspects of Health Education for the Mentally Retarded

Dr. Harold J. Childs, Chairman Physical Education Department, Springfield College
Springfield, Massachusetts

11:30 - 1:30 Lunch

1:30 - 4:30 Health in Relation to Physical Fitness, Rest, Exercise, and Recreation

Mr. John Newman, Associate Professor, Physical Education
Springfield College
Springfield, Massachusetts

Friday, May 14, 1971

8:30 - 9:00 Registration

9:00 - 11:30 The Nurse-Teacher in Health Education

Mrs. Dorothy B. Miller - Role of Nurse-Teacher in Health Education
Consultant, Division of Nursing
State University College at Plattsburgh, New York

Implementation of Health Strands in Special Education

Mrs. Frances Deming, Associate in Nurse Education
Bureau of Health Services
New York State Department

11:30 - 1:30 Lunch

1:30 - 4:00 Health in Relation to Nutrition

Mrs. Marie McGrath, Division of Home Economics
State University College at Plattsburgh, New York

Contribution of Home Economics to Health Education

Mrs. Doris Belton, Associate in Bureau of Home Economics
Division of Occupational Education
New York State Education Department

4:00 - 4:30 Closing

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GREETINGS AND OPENING REMARKS

Dr. Bruce Brummitt, Superintendent of Schools, City School District of the City of Schenectady, New York

We are privileged to have you with us this afternoon. The program for the conference offers some truly unusual opportunities. Your theme is most appropriate. We might turn it around to say that, "Healthiness is Happiness;" that is, if Snoopy doesn't mind. Handicapped young people have the same concerns about growing up and being healthy as their more fortunate brothers and sisters.

I urge you to do all within your power to become more knowledgeable and effective in providing the best in health education for our special children. Perhaps their need is really greater.

A good health education and personal hygiene program could give them one up on other youth and a more equal chance for the good life.

PURPOSE OF INSTITUTE

Salvatore A. Tavormina

On behalf of the Division for Handicapped Children of the State Education Department, I welcome you to this Special Study Institute. We appreciate the cooperation you have given thus far by attending the Institute. Your respective superintendents have expressed their confidence in this type of professional development by endorsing your participation. The planning committee has attempted to develop a format which will make the next three days worthwhile for all of us.

This conference is about health education. Starting in September 1971, all schools in New York State were mandated to offer a program in conformity with the regulations of the Commissioner. These regulations provided that the elementary and secondary school curriculum include health education for all pupils. This applied to mentally handicapped children in elementary and secondary programs.

Such health teaching must largely be done by guiding the children in developing desirable health behavior, attitudes and knowledge through their everyday experiences in a healthful environment. This guidance must include systematic practices of health habits as needed. In addition to continued health guides, provision must be made for planned units of teaching which include health instruction through which mentally handicapped pupils become increasingly self-reliant in solving their own health problems and those of the group. Health education in the elementary and secondary schools must be carried on by the special education teachers with the support of school nurse teachers, health education personnel and physicians.

The educational requirements must be concerned about cigarette smoking, drugs and narcotics, and excessive use of alcohol; as well as all other

aspects of health which include nutritition and hygiene.

For example, there is presently considerable concern about the alarming increase of youthful drug abusers in New York State. At the last session of the legislature, $65 million was appropriated to combat the increasing drug abuse problem. Although the appropriation was aimed principally at treatment and rehabilitation, the Education Department was mandated also to develop a full health and drug education program which was to be coordinated with an overall community effort.

As set forth in the Governor's Model Community Program for Youthful Drug Abuse, the school was to be significantly involved as part of the community effort with the following responsibilities to be assumed in the schools:

1. All Special Education Teachers should learn basic knowledge in the area of drugs in order to include it in their teaching and to help counsel students and refer them to medical help when needed.

2. Health Education Coordinator to coordinate Health and Drug Education, health services and counseling efforts, and to serve as a liaison with community programs.

3. Health Education Teacher to provide in depth drug instruction to students at the secondary level.

4. Counselors and school psychologists to provide primary counseling for students who are experimenting with or abusing drugs.

5. School physicians and nurses to conduct physical examinations (including urinalysis) that will reveal drug use, serve as counselors to students and to make referrals to community rehabilitation facilities as needed.

Thirty-five participants have been invited. Included in this number are special education teachers, school-nurse teachers, health education personnel, selected counselors and supervisors of the mentally retarded.

The institute is sponsored cooperatively by the Bureau for Mentally

Handicapped Children and the Schenectady City School District.

I hope this institute will be a satisfying experience for you. One ingredient I personally consider essential is the opportunity for teacher-to-teacher contact. Your institute director, Jayne Rycheck, has pulled together a program of experts who have many interesting ideas to share with you. My own feeling is that opportunity for teachers to share problems and compare notes is a stimulating part of any institute. The group will be small. By preference, the setting of the institute will be open and informal.

During a given year, the Bureau for Mentally Handicapped Children initiates many institutes like this. We try to sharpen each one. We seek the responses of the participants for future guidance. Although we appreciate hearing favorable things, remember that the most unkind thing you can do is fail to record your dissatisfaction. We are depending on your candid evaluation. This is the desirable way we have to assure that similar mistakes will not be repeated in future institutes. Hopefully, displeasure can be kept to a minimum. Mrs. Rycheck and I look forward to being with you during the next three days.

Best wishes for a good conference.

Associate in Education of the Mentally Retarded

Bureau for Mentally Handicapped Children

THE COMPUTER BASED RESOURCE UNIT: ITS ROLE IN HEALTH EDUCATION FOR NEW YORK STATE

Sarah M. Dunn, Special Project Coordinator
Special Unit on Drugs and Health Education
State University College at Buffalo

THE COMPUTER BASED RESOURCE UNIT
WHAT'S IT ALL ABOUT

Since 1965, many educators have expressed an interest in the Computer Based Resource Unit project originally sponsored by the United States Office of Education, cooperative Research Program. The project was developed at that time at the Center for Curriculum Planning, State University of New York at Buffalo, where evaluation, refinement, and coordination of the project continues. Teachers representing various school systems and colleges throughout the United States and Canada have built Computer Based Resource Units during the past eight years. Each year more resource units are developed, coded, and added to the collection now available.

The purpose of this Computer Based Resource Unit project is to encourage and to aid individualization of instruction by providing the teacher with pre-planning suggestions taken from a large Computer Based Resource Unit. This computer print-out of suggestions to the teacher is geared to:

1. the specific instructional objectives chosed by the teacher for the total class
2. the specific objectives for each pupil
3. the individual characteristics of each pupil

Once the computer is fed requests for specific instructional ojbectives and the characteristics of an individual pupil, the machine generates and prints a resource guide which contains content outlines, suggestions of large group activities, small group activities, instructional materials, measuring devices and suggestions of individual instructional activities,

and materials for each objective chosen.

In other words, each resource guide generated is different from the next.

PRESENTATION OF SLIDE-TAPE ON CONCEPT OF COMPUTER BASED RESOURCE UNITS

Perhaps the best way to review a Computer Based Resource Unit is to discuss what it does not represent.

1. A Computer Based Resource Unit is not a "canned" lesson plan for the teacher; it is a resource from which she can pick and choose specific items of content, activities, objectives, measuring devices and materials to assist her in daily unit planning.

2. A Computer Based Resource Unit is not an instrument which will lessen the teacher's responsibility in the day to day planning. It is geared to the teacher who is willing to do a great deal of pre-planning; working with students, conducting extensive individual instruction and small group instruction.

3. A Computer Based Resource Unit, with its individual student Programs, is not a unit that can be reused in the same individual way for other students in another class. The teacher may refer to it, however, as a resource tool or supplemental information guide.

As you are all aware, a good one quarter of any learning situation rests with the area of pre-planning, individual teacher planning; individual pupil planning, and teacher-pupil preparation.

The Computer Based Resource Unit does insure this at this time, for as the students and teachers explore and analyze the learning objectives for a particular Computer Based Resource Unit, they are able to develop group and individual programs to include: what concepts should be taught (based on content both required and interesting); how the concepts should be presented (through learning activities and materials); and how the acquisition of these concepts should be evaluated (through the use of measuring devices).

THE COMPUTER BASED RESOURCE UNIT AND HEALTH EDUCATION

The Computer Based Resource Unit concept is actively involved in the total scope of Health Education.

A special project, emanating from the State Education Department's Special Unit on Health and Drug Education, was established at the State University College at Buffalo for the purpose of developing the existing New York State Health Strands into Computer Based Resource Units to be readily disseminated to all teachers in Health Education upon request. The text for the individual Health units would initially be extracted from the forty-three currently existing health curriculum bulletins.

Four agencies were selected throughout the State to serve as the centers responsible for the preparation of the Health Strand materials into Computer Based Resource Units. (See Appendix A). To date, the centers are involved with the responsibility of reorganizing and updating existing text in the health strand areas as well as acquiring additional suggestions for learning activities, measuring devices and materials. The centers are also responsible for developing the materials sections for each unit including a complete descriptive abstract for each material listed.

There will be, upon the completion of all center responsibilities, fourteen Health Education Units in the form of Computer Based Resource Units. (See Appendix B).

The goal of the Special Unit at the State University College at Buffalo is the completion of all units by September 1, 1971.

Information will be forthcoming to all School Districts and Health teachers concerning the availability of Computer Based Resource Units and the procedures for requesting the Units for specific class programs in Health Education.

CENTER	DIRECTOR	STRAND MATERIAL
SUC at Brockport	William Zimmerli	I. Physical Health Health Status Sensory Perception Dental Health Disease Prevention and Control V. Education for Survival First Aid and Survival Education
CUNY H. Lehman College	Miriam Tuck	II. Sociological Health Smoking and Health Alcohol Education Drugs and Narcotic Education III. Mental Health Personality Development Sexuality Family Life Education IV. Environmental and Community Health Consumer Health
Cornell College of Human Ecology Division of Human Nutrition	Nancy Miller	I. Physical Health Nutrition
SUC at Cortland	Charles Poskanzer	IV. Environmental and Community Health Environmental and Public Health World Health Ecology and Epidemiology of Health
SUC at Cortland	Leonard Gath	V. Education for Survival Safety

A List of the Tentative Health Units
Planned for Dissemination by
September 1, 1971

The grade level range is also tentative at this time.

NUTRITION	K-12
PERSONAL HEALTH	K-9
SENSORY PERCEPTION	K-9
DISEASE PREVENTION AND CONTROL	K-12
SMOKING	4-12
ALCOHOL *	4-12
DRUGS AND NARCOTICS	K-12
MENTAL HEALTH	K-12
ENVIRONMENT AND PUBLIC HEALTH	K-12
ECOLOGY	7-12
WORLD HEALTH	4-12
SURVIVAL EDUCATION: SAFETY	K-12
SURVIVAL EDUCATION: FIRST AID	4-12

*Additional concentration and development of this unit may delay its dissemination for a short time beyond the September 1st date.

COMMUNITY RESOURCES IN HEALTH EDUCATION AND REEDUCATION

Mrs. Karen White, Senior Recreation Therapist
Wilton State School, Wilton, New York

Just forget where you are for awhile and think of what you'll be doing this weekend. For the majority of us this probably involves some form of recreation, and if it doesn't it should. If we are to believe the theme of this Institute, that happiness is healthiness, we cannot relegate recreation activities to even a position of secondary importance, for, by definition, recreation is any activity voluntarily engaged in during leisure and primarily motivated by the satisfaction or pleasure or happiness derived from it. Most authorities agree that play is an instinct as evidenced by the activity of animals and infants, but for activity to develop beyond this level into more meaningful and satisfying experiences, certain knowledge and skills must be acquired. Handicapped individuals need intensified training in all areas of living, including education for leisure. Very often for the handicapped to participate fully in what has become for others a preoccupation with the pursuit of happiness, he must also be provided with adaptive equipment and facilities, understanding and encouragement from those around him. If not, this avenue of happiness and healthiness will remain closed to him.

There are different areas of recreation and one man's recreation might be another man's vocation. (Re: An editor of a big city newspaper might choose to obtain a guide and pack into some remote area during his vacation, never looking at a paper. The guide, in turn, might choose to relax at home by putting his feet up and reading the evening paper.). Recreation activities can be classified as follows: arts and crafts; drama; dance; social activities; nature activities; services; hobbies; clubs, organization;

and sports, physical development. In their presentation to institution residents these activities must often be modified so that they are in line with the needs and abilities of the individual, but all of these areas should be presented.

Other considerations must be that the program does not conflict with other services (medical, psychological, social work, education, speech and hearing, volunteer, physical therapy, vocational rehabilitation, and ward service). The program must be varied in the following ways: indoor and outdoor, active-passive, organized/instructional-free play, spectator-active participation, on station-off station, ward-general facility, group-individual, all seasons, both sexes, all areas of recreation.

In the event that there are in this audience some throwbacks to the puritan era, when an activity was considered unworthy if it was fun, here are additional ways in which recreation benefits individuals, specifically the mentally retarded.

1. Needs satisfaction - belonging, recognition, competition, adventure, cooperation, fitness, creativity, positive self-image; plus serving as an outlet for the more negative drives of aggression and dominance, and providing for socially acceptable contact with the opposite sex.

2. Builds the individual up to the highest level of physical, mental, social and economic usefulness of which he is capable.

3. Through practicing previously acquired skills (physical, mental, social) and learning new ones, interests will be broadened and latent talents developed, which will in turn, improve health, coordination and personality.

4. Provides an atmosphere for activities in which normality is as nearly approached as possible and encourages appropriate responses to this normality. If, through recreation, an individual can learn self discipline, how to loose gracefully, how to make appropriate decisions, conformity to rules, or become acquainted with specific recreation activities, he has a common ground on which he can react, communicate and relate to the outside.

5. By filling leisure with meaningful, satisfying activity,

individuals who either do not have jobs or whose jobs are repetitious drudgery, can lead enriched lives.

In conclusion, recreation may not be the panacea for all ills, but in a proper relationship with other life supporting activities and rest, meaningful leisure activity can mean the difference between living well and just living.

HEALTH EDUCATION FOR THE MENTALLY RETARDED
BROAD ASPECTS

Dr. Harold J. Childs, Professor, Health Education
Springfield College
Springfield, Massachusetts

When Mr. John Neumann informed me of the invitation to take part in this "Special Study Institute," the first thought that struck me was what a challenge. Health education for the mentally handicapped is such a wide-open field; so much needs to be done. I wondered if I could do justice to the challenge presented me in this invitation. My major preparation and experience is in the field of Health Education; not health education specifically for the handicapped. My mind jumped from one possible mode of attacking the challenge to another, and still another. And, to make a long story short, after considering the possibilities, I decided I would enjoy the opportunity of sharing ideas on the subject with you and so accepted the invitation.

Generally speaking, I like to organize my presentations within a format which includes an overview, at least one or more approaches to the problem, selected examples of learning experiences which can be employed in order to bring about the greatest amount of functional learning, and end with an appropriate amount of time provided to engage in a give-and-take discussion with those who are in attendance.

I have included a selected bibliography, briefly stated learning activities for the major topic areas included in health education, list of resources in health education, with a copy of my presentation which have been submitted to your chairman, Jayne Rycheck. I understand a brochure of the Institute will be prepared and made available to participants.

With this format in mind, I will take the first portion of the time provided for my formal remarks. After the break, let us engage in dialogue.

I - OVERVIEW

I propose to limit my remarks to the mentally retarded classified as educable and usually included in the public school program of today.

More and more authorities recommend including the educable mentally retarded in the public school program. They feel a more realistic adjustment to life can be made by the retarded because of the valuable experience they have gained through participation in a planned program in education designed to aid them in acquiring skills in decision making and behavior. If we are to meet the challenge we must provide increasing opportunities for these people to achieve independence, or at least a measure of independence, and take their rightful place in American society. Too many in the past have been thrust upon society ill equipped to meet the demands of life. Many have married, reproduced, and lived with reasonable success. However, many others have experienced mild to extreme frustration and unhappiness in their attempt to live in a complex society. They married, reproduced, sometimes without the benefit of marriage, and raised troubled unhappy, unhealthy children. And in many instances, most of this could have been prevented; at least modified.

We have to act now, if we are to be successful in reducing the number of mentally retarded who are experiencing failure and unhappiness in their attempt to find an acceptable place in society. I say this because the task becomes more and more difficult each year, because we have a greater number to deal with each year. Also, if we think American society is complex and over crowded now, with two hundred million plus population, keen competition for living space, jobs, food, recreation, and the many

other necessities of life, stop and think of the future. With increased population, increased mechanization, increased competition for space, jobs, and all of the necessities of life, and an increasingly more complex society, the mentally retarded will be in an even more disadvantageous position than they are now. Especially if their numbers increase; and, we do not seem to be very successful in preventing an increase in numbers as of this date. We must act now in all of the ways appropriate action is possible.

The task is one with many facets. We need to discover and control as many of the causes of mental retardation as we can; PKU, Glactosemia, German Measles, etc. And, we must become more effective in assisting those cases we cannot prevent to become as effective and happy citizens in a dynamic society as possible.

II - An approach to the challenge.

Specialists in the field of mental retardation have provided, and will continue to provide, helpful information as a result of research. One of the most difficult tasks is to use this oftentimes conflicting information in meaningful ways to establish objectives, plan programs designed to achieve these objectives, and to provide the staff and facilities to implement these programs.

A variety of authors have written on the subject of programming. Most of these treatise include the following steps:

1. Establishing a working committee comprised of the most knowledgeable people representing all who should be concerned with the problem to be solved. Health education content suggestions can be found in publications produced by textbooks companies, the SCHOOL HEALTH EDUCATION STUDY and 3M corporation, Guidelines provided by state education departments and state public health departments, (New York State Education Department, STRANDS I through V), special groups, (A RESOURCE GUIDE IN SEX EDUCATION FOR THE MENTALLY RETARDED, by the School Health Division of the A.A.H.P.E.R. and Sex Information and Education

Council of the United States), etc.

2. Establishing and agreeing upon the objectives to be achieved through a program to be formulated. Such as meeting needs, overcoming problems, etc. Health needs most often associated with personal hygiene, nutrition, stimulants and depressants, sex education as a part of social action and family life education, and consumer education.

3. Drawing up a proposed program designed to achieve the objectives.

4. Obtaining appropriate personnel to implement the proposed program; usually on a pilot demonstration basis first. inservice training of the special teacher may be necessary.

5. Careful implementation of the pilot demonstration program, involving continuous supervision and evaluation. Criteria for evaluation will undoubtedly need to be determined for these special adapted health education programs for the mentally retarded.

6. Revising the program in terms of the experience gained through evaluation of the pilot demonstration. This could be in terms of content selected, mode of exposure, learning experiences, timing, speed of exposure, audiovisual aids, grouping, and many other factors.

7. Realistic implementation of the revised full scale program. Appropriate coordination, supervision, evaluation and revision should be considered.

I am confident all here in attendance are aware of this standard procedure for embarking upon a new program. I mention it merely as a stage setter, since programs of health education for the mentally handicapped or retarded are not found in many of the school systems today. Or, if such programs do exist, one or more to the important controversial content areas in health education usually included in a sound program have not been included. Much of this is due to the fact that ultra-conservative groups such as the:

John Birch Society
MOMS - Mothers for Moral Stability
SOS - Sanity on Sex
AVERT - Association of Volunteers for Education Responsibility in Texas

have successfully influenced decision makers to leave these areas out of "guides."

One of the most difficult, but all important, areas of understanding school personnel must acquire is the fact that many, if not most, of the mentally retarded youngsters entering school already have a negative perception of themselves.

The youngster may be resigned to the "fact," that "I am stupid," incapable, unacceptable, unlovable, etc. This is entirely possible because self concept formation begins in earnest about age three or four. This poses difficult challenge in health education since one of our objectives is to favorably influence mental health. And mental health status is dependent upon self concept.

However, if a warm, accepting, stimulating, capable teacher is assigned to work with such a youngster, in an appropriate setting, positive self concept building is possible. This is health education. And, with the reality of individual capacity careful considered, the youngster comes to see and respect himself. The earlier in the grades this is experienced the better. For, as each year passes without this accomplishment the task is made more difficult.

The school must be aware of the many factors and forces exerting their influence is that of his parents. Parent-Teacher, and/or Parent-Teacher-Special Education Counselor conferences are often necessary in order to establish a meaningful health education experience for the youngster. For example if such a conference reveals the parents have not totally recognized and accepted the fact that they have a retarded child, the school often through the teacher, must find acceptable avenues of approach to assist the parents in accomplishing this objective. On the other hand, some parents have recognized the retardation, but tend to be hostile and rejective in their relationship with the youngster. Still another reaction of parents to the recognized mental retardation of their youngster is overprotection.

They act for the youngster every time he may possibly experience frustration or failure; often actually believing they owe this to their "unfortunate child."

These reactions of parents, may be because they experience frustration in working with the child, resentment over being dealt such a "low blow," guilt because somehow they might have prevented the condition if they had done something differently, guilt over the conviction that this child will marry and produce children who will be retarded, anxiety over what will become of the youngster when they, the parents, are no longer around to protect the child, etc.

Whatever the reason for these reactions, the parents may never have stimulated the youngster to learn the basic physical, mental, emotional and social skills, within their capacity to learn, which are necessary for them to meet the demands of school and life.

In summary, it seems to me there is rather convincing evidence that educators must work with small numbers of mentally retarded youngsters they get to know extremely well, since these youngsters have about the same needs, feelings, desires, etc. as the so-called normal youngster; with the exception being that they are limited and confused in their approach to attainment. Further, it seems to me, that the majority of health education content provided the "normal" student must be shared with the mentally retarded; that an appropriate exposure rate must be determined for each area of concentration; and, that the learning experiences provided must be even more carefully selected than those for "normal" students. For example: a number of special education teachers have found the lower level educables become confused when more than one stimuli is introduced at the same time (filmstrip and sound tape). If establishing rapport is important in achieving success in health teaching with "normal" students it is vital with the mentally retarded.

Perhaps the most important thing one can say is that no single guideline in health education will serve all classes of retarded youngsters. And, in fact, every guideline, every method, every technique, every teaching aid, and every learning experience must be adapted to the unique personalitie comprising each class in order to approach success.

The remaining suggestions are offered merely as a sample of the possibilities creative and innovative teachers can contribute to the field. However, the general objectives of education and health education remain the same:

1. Achieve self realization
2. Develop appropriate human relations
3. Attain economic defficiency
4. Assume civic responsibility

You will recall that I mentioned a few health education areas of study where mentally retarded youth need more of an opportunity of exposure than others. Namely, nutrition, personal hygiene, stimulants and depressants, and sex education and family living. I would like to take one of these areas and explore the possibilities for health instruction and perhaps others as time permits.

III - The suggested learning activities sheets attached will serve as examples for discussion.

OUTLINE

HEALTH EDUCATION FOR THE MENTALLY HANDICAPPED CHILDREN

IN ELEMENTARY AND SECONDARY SCHOOLS

John L. Neumann, Associate Professor of Physical Education
Springfield College
Springfield, Massachusetts

Physical Fitness, Rest, Recreation

I. The Dimensions of Total Fitness: Interrelated and interdependent-wholeness of man

- A. emotional
- B. social
- C. mental
- D. spiritual
- E. physical

II. The Primary Components of Physical Fitness

- A. Muscular fitness
  - 1. strength (static and dynamic)
  - 2. endurance-stamina (local and general)
- B. Organic fitness: (cardiovascular or circulo-respiratory)
  - 1. heart
  - 2. lungs
  - 3. blood vessels

III. Motor Fitness

- A. speed
- B. agility
- C. power (explosive)
- D. balance (static and dynamic)
- E. flexibility
- F. coordination (integration of movement)

IV. Related Factors

- A. relaxation
- B. diet
- C. physique

V. Important Questions to be Answered

A. Physical fitness for whom, for what, and how much?

VI. Important Principles to be Considered

A. Medical examination prior to vigorous activity

B. Motivation

1. doubtful if the retardate can conceptualize the need for physical fitness

2. activities must serve an emotional need - must contain an element of FUN

C. Skill level must be met or achieved in order to promote effective physiological benefit

D. Specificity: the body will respond to those activities it is forced to perform

1. S.A.I.D. Principle

E. Overload: current levels (maximums) must be surpassed in order for improvement to take place

F. Progression: experiences must be gradually made more difficult after a firm base has been established for both skill level and physical tolerance

G. Activities should improve each of the primary components of physical fitness as a foundation for later more specialized factors of motor fitness

H. Appropriateness: program should consider age, sex, skill level, and all affecting circumstances

Testing for Physical Fitness

I. Criteria of a Good Test of Physical Fitness

A. Does it measure the primary components and/or desirable factors?

B. Does it have reliable norms for girls and boys at various ages?

C. Is it easily administered - economy of time and effort?

D. Does it have levels of achievement, awards, motivation, incentive?

II. The A.A.H.P.E.R. Kennedy Foundation Special Fitness Test, and Frank J. Hayden's Tests for Muscular Fitness, Organic Fitness, and Physique meet these criteria.

III. The most important aspect of testing is what is done with the results- not the collecting of the scores!

A. Constant programs in accordance with test results

B. Measure the worth of your program with post program test and evaluate your efforts

Considerations for the Program

I. Designed according to needs - evidenced by knowledge of the group (all possible input), test results, facilities and equipment, staff, number of students, etc.

A. Reminders for program design

1. skills
2. motivation
3. progression
4. medical examination
5. overload
6. regularity essential
7. fun
8. variation

II. Development of Foundations for Motor Activity (interrelatedness)

A. Spatial relationships

1. tunnels
2. mazes

B. Body awareness

C. Continuity of movement: control of the body and adjusting to environmental cuses

1. stopping
2. starting
3. accelerating
4. changing direction

D. Balance: countering gravitational force and orientation

1. balance beam
2. balance board
3. trampoline
4. tire ("sinking") walking

E. Concept of time: changes and variation of the speed of movement-rhythm

1. music, cadence, tempo, etc.

F. Levels: efficiency of movement from different postures

1. walking
2. running
3. crouching
4. crawling (hands and knees)
5. creeping (on trunk)

G. Weight Transfer: transference of body weight from one foot or hand to another, or alternately different body parts

1. hopping
2. tumbling
3. jumping

H. Force acceptance and production

1. striking
2. pushing
3. kicking
4. throwing

and

1. landing
2. catching

I. Force adjustment: controlling or adjusting force to achieve a desired end

1. shooting a basket
2. throwing a ball

-- different target levels

J. Locomotion: all forms of movement from one place to another, any kind

1. skipping, running, crawling, etc.
2. combines many of the others

A Program Should Incorporate These Fundamental Activities

III. What kind of program should be used?

A. calisthenics
B. weight training
C. isometrics
D. interval training
E. circuit training
F. combinations

Perhaps the best is one that uses elements of all five traditional programs

1. Recommend a combined circuit and interval training procedure

IV. Regardless of the program, the following must be addressed

A. Selection of exercises or activities

B. Order of the exercise

1. don't overstress; alternate body regions

C. Management of

1. time
2. load -- Intensity of the Workout
3. repetitions
4. rate

D. Grading of exercises for greater stress, i.e.:

Pushups - 1. wall pus aways
2. knee pushups
3. standard pushup
4. elevated legs: pushups

- Arm Strength

E. Fitness Activities Perhaps Best Performed at the End of a Period

1. 10-15 minutes in length
2. doesn't reduce efficiency for skill development earlier in period

F. All exercises or activities must be previously explained, demonstrated, and performed by the retardates

V. Same Physiological Principles

A. Strength - endurance continuum for development

Strength ----	----Endurance
High weight or load	Low weight or load
Few repetitions	Many repetitions

B. In order to produce greater cardiovascular efficiency - training effect

1. heart rate must be elevated to approximately 60-70% of maximum and maintained there for five minutes------the longer the greater the training effect

2. for adults this represents a heart rate of 140-150 beats/minute during an exercise

C. Principle of interval running

1. exercise,-recover, exercise, recover

2. jogging, Ken Cooper, Aerobics

3. maximum oxygen consumption

D. Physiological overload

1. modifying the variables of time, load, repetitions, rate, to produce the desired effect

The Combined Circuit - Interval Run Program

A "circuit" is a given number of selected exercise (or activities) specifically arranged with a designated intensity of load and time directed toward:

1. development of muscular and circulo-respiratory endurance

2. progressive loading (three levels of intensity standard design)

3. accounting for individual and group capacities and administration

"Interval Training" is exercise over a predetermined time or distance with alternating periods of increased stress (intensity) and light (minimal) activity. May be simply running.

Some Specific Objectives of the Circuit and Interval Run:

1. development of basic (foundations) for movement

2. development of muscular strength and endurance

3. development of cardiovascular efficiency

4. provision for graded activities

5. provision for variety of similar activities

6. ease of administration

a. use of tape and music recommended

Organization - Methodology

1. six (6) activity stations (arranged in circle)
2. forty (40) seconds of exercise at each station
3. approximately ten (10) seconds change time between stations
4. five (5) minutes of interval running
   a. jogging
   b. crossover steps
   c. skipping
   d. leaping both feet (coordinating arm swing with hop) stutter step
   e. walking, running, one foot hops
   f. etc.
5. repeat circuit and interval run if appropriate

COMBINED: TIMED CIRCUIT AND INTERVAL RUN PROGRAM

#1
Medicine Ball Push 4 lbs.
Wall Pushaways
Playground Ball Wall Bounce

..40 seconds at ..
each station

#6
Rope Jump
Bench Step/Wgt.
Squat Thrusts

#2
Balance Beam (4")
Agility Run
Variation Balance Beam
1. up and down tilt
2. left or right tilt

.. 10 seconds ..
between stations

#5
Tunnel Mats
Sit Ups & Variations & Wgt.
Front-Back Positions
(thru, over, and under)
Mat tumbling and/or
log rolling variations

#3
Hula Hoops
Body Image Box
Hoop Variations & Explorations

TOTAL CIRCUIT TIME
5 Min.

#4
Balance Board (eyes open and closed)
Variations/Ball Bounce
Agility Run

Interval Run around gym (use lines for direction, guide, and activities)
2 minute activities, 1 minute walk, 2 minute activities

TOTAL INTERVAL RUN TIME
5 MIN.

PHYSICAL FITNESS FOR THE MENTALLY RETARDED — Frank J. Hayden

HOW MUCH? HOW OFTEN? HOW HARD?

How Much? The following are estimates of the minimum times required to provide adequate exercise of each type for severely retarded children. These are minutes of actual exercise for each child and may be somewhat less than the total class time required.

Organic fitness activities	- 10 min.
Muscular fitness activities	
Legs	- 5 min. (may be the same as organic)
Back	- 5 min.
Arms and shoulders	- 10 min.
Abdomen	- 5 min.
Flexibility	- 5 min.

How Often? Every class day should contain a period of supervised physical education. These periods should include fitness activities as follows:

Organic fitness activities	- Every day
Muscular fitness activities	
Legs	- Every day (may be the same as organic)
Back	- 3 times per week
Arms and shoulders	- 2 times per week
Abdomen	- 2 times per week
Flexibility	- once per week

How Hard? Severely retarded children can and must exercise more strenuously than is presently realized. Objective criteria for evaluating the strenuousness of activities are very difficult because of the great individual differences in retarded children. Generally speaking, organic fitness activities should be vigorous enough to:

1. produce some shortness of breath (puffing)
2. increase body heat (sweating, face flushed)

Muscular fitness activities should be vigorous enough to:

1. require concentrated muscular effort
2. produce muscular fatigue (tiredness) resulting in decreased performance.

Of course these estimates of how much, how often, and how hard may be modified by the individual needs of your children and their rate of improvement as revealed by your test results.

Northeastern University
Boston Bouve College
Department of Physical Education for Men

Selected Guidelines for Teaching the Mentally Retarded Student

Professor Royal L. Goheen

1. Structured warm-up activities can be successfully utilized with the MR student, however, less emphasis should be placed on regimentation and/or perfection and more on mimetics and opportunities for self-expression.

2. Highly formalized organizational techniques should be dispensed with if possible.

3. Such innovations as drawing numbers for floor "spots" seem to be readily accepted by most MR students.

4. Much less emphasis should be placed on the explanation phase of teaching; careful demonstration followed immediately by meaningful practice is very important. Concrete-type explanations are generally more effective than those approaching the abstract.

5. Concerning a high degree of educability there are at least two important considerations to be aware of:

    1) This student will, in all probability, cause the most serious discipline problems.
    2) This student will usually grasp the skill much more quickly.

6. Because most MR students like to follow and/or mimic, follow-the-leader type activities are generally quite effective.

7. Praise generally produces more effective reaction than does reproof.

8. The recognition of success, by the instructor, is extremely important.

9. Interest spans of MR students generally are not of a long duration.

10. Even minor distractions can markedly affect attention spans of the MR student.

11. A verbal rebuke often successful with the normal student is not generally effective and extreme patience must be exercised!

12. Generally, if a MR student does not want to participate (Mongoloids will often do this) he or she should be allowed to look on from the sidelines but not be permitted to play at other things.

13. Because of potential problems, the number of groups utilized within a class setting should be kept at a minimum. It is wise to remember that the number of students should not exceed twelve, with eighteen as an absolute maximum.

14. Equipment and supplies not being utilized should be kept in a storeroom. If this is not done students of lower educability are very apt to leave the group and embark on a new venture.

15. Innovations such as well-constructed wooden boxes, oversized balls (with varied colors), deflated balls, roped-off lanes, etc., are important in helping the MR student to learn more readily.

16. Slightly more than one clock hour is recommended for most MR students with forty minutes being utilized for activity and the balance (about 30 minutes) for dressing and showering.

17. Habits of personal health and grooming often are overlooked by the MR student and they need to be constantly reminded and praised when they do attend to detail by themselves.

18. Circle or semi circle formations are generally more desirable than straighteline formations.

19. The MR student generally will react more favorably to a familiar formation and/or activity.

20. The MR student can be tested via conventional measurement instruments although perhaps more attention should be given to teacher made devices which are directly suited to the group.

21. When working with the MR student it is more practical to group by age, if there is a variance, than by ability.

22. Concerning specific activity:

    1) Basic movement skills learned earlier can be directly applied by the MR student to a meaningful play type situation.

    2) It should be remembered that free play type activity and/or creativity is essentially dependent on recall of immediate past experience.

    3) Multiple movement type activities, although frustrating to some of the students of lower educability, can be successfully grasped.

    4) Selected team sports are practical for usage with the MR student.

    5) Elementary stunts, tumbling, and apparatus can be very effectively taught to MR students.

    6) Obstacle courses used for purposes of screening, changes of pace and evaluation are generally quite effective.

    7) Elementary activities including those of low organization; simple ball games; relays and rhythms can be successfully used; however, this should not be done at the expense of more meaningful activity.

23. Although objectives are essentially the same as those adhered to in a normal situation (fitness, skills, knowledges, social and carryover) emphasis should be placed on the social-emotional aspects and carryover values while slightly less time can be devoted to the teaching of knowledge and understanding. Physical fitness and the learning of skills are both extremely important.

THE NURSE-TEACHER IN HEALTH IN SPECIAL EDUCATION

Dorothy Miller - Consultant in Health Education
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Those of us who have been in the school health field for a number of years have observed a complete transformation in the provision of medical services and educational programs for children with handicapping conditions. We have seen much progress in understanding and in accepting the individual child with the emphasis shifting from the handicap to the child. The conservation and cultivation of the abilities of the individual, the improvement of his disability so far as it is possible and the utilization of all available means to help him develop abilities, replacing those which cannot be restored, have become objectives.

Increased public awareness of the problems facing children within this broad category has brought about community support for appropriate programs and services. We have observed a changed attitude, generally, on the part of parents of these children. No longer are they reticent to seek help, but have joined with other parents to form associations through which they have demanded the same rights as those for "normal" children. As a result, state and federal legislation has provided funds for the development and maintenance of such facilities as are indicated.

Universities have established departments for the preparation of personnel in specific skills found most effective thus far in the curriculum of special education. We find workshops, such as yours, set up in increasing frequency throughout the state and attended by various representative disciplines, administrators, teachers, psychologists, guidance personnel and nurse-teachers for study and exploration.

The nurse-teacher has been very much a part of this progress. She is a member of the staff educated first in the nursing field, public health, then in education, guidance, counseling and educational psychology. As a member of the multi-discipline pupil personnel services, her role is essentially supportive and essential to education. All activities are education-oriented. She is also frequently involved in classroom teaching and serves as a valuable resource to the teacher in health education. Administrators involve her in pertinent aspects of staff education, as well. Her professional proficiencies as the health specialist in the school setting offer significant contributions toward a better understanding of the child's health status in relation to his learning ability.

As you well know, the nurse-teacher's responsibilities encompass the welfare of all students in your school, the scope is extensive. Her job is challenging in that she functions in all areas with all personnel from the custodian to the administrators. Her efforts, however, would be limited in effectiveness were she not to participate with others outside the school environment. These include parents, the private medical practitioners and other specialists, personnel in clinics, hospitals and a variety of other community health and social service agencies. Always working within a team concept (the team consisting of appropriate personnel within and outside the school,) she also serves as the liaison to coordinate information from all essential resources directed toward the individual child.

In no other area is it more important for the nurse-teacher to function skillfully within the total home-school-community framework than in that area of handicapped children. What are her responsibilities to the exceptional child and do they differ from those for all children? Fairly recently the State Nurse-teachers' Association conducted a workshop to analyze this question in depth. It was concluded that responsibilities do not, in fact, differ. The school health program goal is directed toward assisting every

child to achieve and maintain that optimum level of physical, emotional and mental health of which he is capable. Since there exist varying degrees of "wellness" among all children, each child must be studied individually in order to provide intelligently those health and educational services which are appropriate for him. And, so, each child with a handicapping condition within the total special education category receives all those services available to any school child plus any additional services which will assist him to greater advantage. The answer, then, lies in depth and degree of extensiveness of effort.

The nurse-teacher's involvement with children with special needs begins as soon as they are known to her, since early treatment is essential. Case-finding is an important aspect of the total planning program, so it is essential that the nurse-teacher has established good communication and working relationships with others in the local community. How effective case-finding procedures are varies from community to community. Even though mental retardation, the subject of this conference, is a problem of the community in so many ways, we continue to suffer with the inefficiencies as a result of disjointed isolated efforts. I think the time has come for realistic action in total community health planning, with the school health services represented and participating. More effective comprehensive planning and coordination of agencies would certainly result in better services and programs for all at least in cost of effort and money. We must take a good hard look at the serious polarization between the consumer and the provider of health care which exists today and, in concert with others, define our concepts and objectives. School personnel could well take the leadership in such an undertaking; do we not have the population which provides the evidence?

The mentally retarded child requires a comprehensive medical and psychological evaluation through a multi-discipline approach to determine a diagnosis and treatment plan. It is valuable for him to have a detailed history including family, prenatal, perinatal, neonatal and general medical history including growth and development, also a summary of psychologic, speech, neurologic, orthopedic and dental studies. Other consultations such as ophthalmologic, otolaryngolic may be provided as indicated, as well as many other laboratory tests and investigation. The nurse-teacher may initiate this investigation, may play a part in it - as compiling the detailed history - or may need to gather the total information together, if such services have been completed. Accumulating all appropriate information may be very time-consuming, but it is invaluable as a reference for the school's personnel in determining his program.

Once the child has been entered into the appropriate school program, the nurse-teacher needs to interpret that technical health information about the child in a practical manner to teachers and other school personnel who may be involved with him and define its significance to his program. We recognize that mental retardation is an effect, rather than a disease in itself, and simply means that the child has not developed intellectually to the level expected of his age group. However, again, his degree of "wellness" is unique to him and needs to be understood. Perhaps he is receiving medication for a convulsive disorder. Observation for certain symptoms may be indicated which can be transferred to his physician. Should he have a visual or hearing problem, advantageous seating may be necessary.

Occasionally misconceptions must be corrected - and these still exist in the area of the retarded. Straightening out problems of this nature

requires tact and a professional objective approach on the part of the nurse-teacher.

Parent counseling, initiated earlier - hopefully during preschool - needs to be sustained in order to interpret the child's adjustment in the school program. Reassurance to the frequently-observed anxious parent may be crucial to the child's security away from home. Suggestions may be offered to improve the child's home care program in order to better coordinate with the teacher's efforts in the classroom. The nurse-teacher must be sensitive to those "indicators" of children and parents which require on-the-spot help - and may work together with the social.

We may sometimes see mentally retarded children fall into the hands of "quacks" - simply because parents have not been helped to accept the realistic limitations of their children. I recall the mother of a trainable child - who had recently moved into the district - explaining to me that her child had, during the summer, been treated by a "specialist" in Arizona - and that he had guaranteed that the child would be "perfectly normal intellectually" in two years if she continued to carry out the program that he had prescribed. The child had been flown to Arizona with a sister and the treatment, explained by the mother, consisted of the manipulation of the child's brain, through massage of the roof of the mouth, into its proper position in the skull from its previous cramped position wedged into a corner behind the ear. For this she had paid $5,000 plus the cost of travel and living expenses and was involved in an expensive usless "training program." This was a low income family - without a father - and all available relatives had contributed to help. Counseling of parents following exploitation of this severity becomes extremely difficult and must be approached with the greatest skill and an awareness of the appropriateness

of timing. All of us in the the schools need to remain aware of the possibilities of exploitation of the mentally retarded and to recognize the position of vulnerability of parents through which they become dupes of the unethical and unscrupulous.

The nurse-teacher, together with the teacher and school psychologist, continues to observe the child in the classroom setting and provides that counseling to him which is needed to help him face and accept his problem, whatever it may be, as realistically as possible. As we all know, adjustment in the school program may be a difficult struggle for the child limited in intelligence and with a physical or emotional problem as well. He needs every bit of support possible.

Occasionally it may become necessary for the nurse-teacher to prepare a group for a handicapped child's entrance. If, for instance, the youngster has an obvious physical anomaly, it can be explained in simple terms while stressing other more positive characteristics. This assists in acceptance by his peers and also helps children to recognize that all have individual characteristics making up the total personality.

Quite often it is the intuitive know-how of the nurse-teacher which helps to keep the youngster in school. Rest periods may be needed or a shortened school day may have to be worked out with the Transportation Department. The child arriving tired and without breakfast may need some food from the cafeteria. The child with a fractured leg may need some help in getting around with his crutches and a friend to carry his books. The diabetic may need medication and some supplementary food. Such possibilities are numerous, as you well know, but, in a child-centered situation much can be done to help provide a situation in which the handicapped child may feel comfortable and secure.

An amendment to the Regulations of the Commissioner of Education, issued within the past few years, requires that a committee of appropriate personnel be established in the schools to review and evaluate the progress of each child with a handicap at least once a year. This can be a great help since the interest of several disciplines is focused upon that one child, hopefully all supplementary resources necessary will be pulled together to support him in his development. The nurse-teacher should certainly be a member of such a committee for the contributions already mentioned.

The actual classroom health education of the mentally retarded child remains the responsibility of the classroom teacher, at least on the elementary level. However, as observed in your conference program, there exist many components of health education and many people contribute in many ways. Health education is, after all, the reason for the nurse-teacher's existence in the school system. The many endeavors which I have discussed are all related to the overall area of health education - whether they be investigative, supportive or remedial in nature. In the development of the health education curriculum the nurse-teacher, as the health professional, should be a key participant. In the implementation she serves as a consultant to teachers.

What is the objective of health education? Could it not be described as helping the individual to develop a design of living for himself? Children grow in understanding as a result of many and varied experiences. It cannot be questioned that it is the school's responsibility to provide those selected experiences which will help children develop responsibilitiessfor a pattern of behavior for healthful living. The Critical Problems Act passed by the New York State Legislature, states: "...the educational

requirements regarding cigarette smoking, drugs and narcotics and excessive use of alcohol set forth in this act become the basis for broad, mandatory health curricula in all elementary and secondary schools. Such curricula shall include instruction appropriate for the various grade levels in nutrition, mental and emotional health, family living, disease prevention and control and accident prevention." As a result of attack by various political and religious groups, the phrase "family living" was deleted; however it is neither prohibited nor mandated but left to the decision of the local community; (nurse-teachers may be influential here!) In viewing the areas mentioned in this Act, one realizes the significance of such information for the mentally retarded child. It is basic to his preparation for life. Is it nor our overall goal for the mentally retarded to help him become a responsible and independent citizen, in spite of his limited ability?

In developing the health education curriculum, I would hope that it might be planned around the concerns of the children themselves. They can relate what they want to know about - if we only listen! He wants to know how to care for himself; to learn about those foods which will help him grow; to know why he should avoid those problem areas which we are so concerned about today for all our youth (drugs, alcohol, smoking). He needs to be helped to develop a good concept of himself, his own sexuality and to relate effectively with others. He must be given the freedom to question, search and to make mistakes. He learns by doing and through repetition, we must have much patience and understanding together with wise guidance.

There should be many opportunities for the educable youngsters to be integrated into the health education classes with the regular class students. Preparatory and supplemental instruction by the classroom teacher is, of course, necessary - but these children need to get out of their isolated

classrooms whenever possible. After all, they are not going to be living only with the retarded once they leave school.

The nurse-teacher may be requested by the classroom teacher to instruct in certain areas of the curriculum in which she may be particularly knowledgeable. She may provide health information materials from her resource file and secure appropriate films and filmstrips. She may also be helpful in soliciting speakers as guests from the community health professions; arrange visits to dentist's office, health fairs, etc. Health projects, very meaningful to the retarded, may be cooperatively planned for. Extending these efforts for parent participation may, of course, make for more far-reaching and lasting effect.

Finally, responsibility to the retarded student extends to helping him and his parents plan for his future; counseling him toward making appropriate job selection or workshop facility. In this, school personnel usually consult with a vocational counselor and here, too, the nurse-teacher enters the picture to interpret any health conditions which require placement consideration.

In conclusion, it is quite obvious that more is needed and expected of the nurse-teacher as each year passes - and rightly so. Her unique capabilities have far too long been wasted on time-consuming non-professional duties. It is now time to re-examine objectives - establish priorities - and delegate those "lesser" activities to para-professionals. When this can be accomplished you will find even more participation in health education by the nurse-teacher.

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HEALTH IN RELATION TO NUTRITION

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Concept:

A teacher who is educated in the science of nutrition is an asset to the present; and an investment in the future.

Generalizations

1. To be well fed does not guarantee sound nourishment.
2. Modern nutrition is set in a framework of both social and biological sciences.
3. Changing food habits is a complex problem.
4. There seems to be a need to teach each new generation how to use its existing food supply intelligently.
5. Hungry children cannot learn; malnourished children do not grow or develop and are incapable of learning.
6. Advances in nutritional well being must come from individuals doing for themselves rather than from authoritative control.
7. Nutrition education is a process - a process which is concerned with behavior. It is concerned with what people do and not with the knowledge they have in nutrition.

1. To be well fed does not guarantee sound nourishment.

The science of nutrition is simply defined as the science of nourishing the body properly. This, therefore, means all of the nutrients, improper amounts to meet the requirements of body functions. Food and nutrition are interdependent, and regardless of the definition I use - the procedure that I follow, to select, buy, and prepare the food that I eat (or for those for

whom I am responsible) is most significant to the physical well being of the individual.

* Show the transparency of the Basic 4.

Now that I have shown you the Basic 4 groups of food from which you can choose each day, week, etc., let us look together at the nutrients for which my body has a daily need.

* Show transparencies in this order:

Carbohydrates

Fats

Proteins

Vitamins

Minerals

Water

Discussion of each

We all need to broaden our concept of malnutrition.

It is one of four situations:

a. not enough food available

b. food available, but not a variety of the right kinds of food

c. all kinds of food available, but the wrong choices of food

d. too much food

In America we are deeply concerned for those whose diet are deficient, but let me remind you of one most important fact; you are equally as malnourished by excess as by deficiency. We are proceeding nationally on preventative health care related to diet to avoid:

the overweight baby

the overweight teenager

the overweight adult

preventative cardiac nutrition

preventative dental caries diets

2. Modern nutrition is set in a framework of both social and biological sciences.

Nutrition is not an entity unto itself. It draws heavily on and contributes to all other life sciences.

Biology: - Functions of nutrients

Chemistry: - formula and analysis

Biochemistry: - chemistry of living material - i.e. carbon compounds etc.

Microbiology: - food borne organisms - food preservation

Physiology: - digestion

Medicine: - Vitamins or Iron as therapy

Cellular Biology: with the use of radioactive isotopes, it is possible to study the metabolism of individual cells and even sub cellular components or organelles of the cell

Nutrition's role in the behavioral sciences is an unending fascination to me.

Anthropology: - the study of food habits is basic to understanding the culture of the people (M.Head)

Sociology: - life style in relation to eating habits

Psychology: - what do you overeat?
when do you overeat?
the role of color, flavor, taste - sight and smell

3. Changing food habits is a complex problem

What is your favorite food?

What is your favorite meal?

What does food mean to you?

Do you only eat when you are hungry - or do you eat at a meeting

or when people visit you

or do you not eat when you are alone

How many meals a day do you eat?

3? 5? 7?

What foods do you think of when I say breakfast foods?

What foods connotate

status?	Mother?
health?	Father?
sick?	Cheap?
Sunday Dinner?	Sorrow?
Easter?	Childhood?
Thanksgiving?	

Where do you live in the world?

Where do you live in this country?

Where do you live in this state?

What nationality are you?

What is your income?

How many are there in your family?

Do elderly grandparents eat with you?

Does someone in your family have a chronic illness?

What is your occupation?

Does your wife work?

What equipment do you use to prepare food?

a broiler or a frying pan

a steamer or a kettle of water

a deep fat fryer or an oven

Answer all of these questions and I can start to analyze your food habits - but can I change them? If so, how?

What are your values? and mine?

4. There seems to be a need to teach each new generation how to use its existing food supply intelligently.

You have all heard the statement - "My grandfather didn't know about vitamins and he did pretty well."

I do not have time nor is this the occasion for me to tach you to use all of your existing food supply intelligently but I will hit upon a few significant facts that are close to my heart.

Examples: 1. Show transparency on fruit juice and fruit drinks.

2. Discuss canned soup vs. homemade soup.

3. Cold meat vs. cooked meat and sliced cold meat.

4. Hot dogs vs. peanut butter.

This kind of information is so readily available that I do not wish to use your time here.

NUTRIENT	4 OZ. ORANGE JUICE	4 OZ. TANG
Protein	2 grams	0 grams
Carbohydrate	13.5 grams	14.9 grams
Fat	0	0 (hydrogenated vegetable oil is on the label)
Vitamin A	250 I.U.	1320 I.U.
Vitamic C	56-92 mg.	81 mg.
Iron	.2 mg.	.1 mg.
Sodium	1 mg. (water variable)	50 mg.
Calories	55 calories	66 calories

NUTRIENT	1 HOT DOG	1 T. PEANUT BUTTER
Calories	155	95
Protein	6 grams	4 grams
Fat	14 grams	8 grams
Carbohydrates	1 gram	3 grams
Calcium	3 mg.	9 mg.
Iron	.8 mg.	.3 mg.
Thiamine	.08 mg.	.02 mg.
Riboflavin	.10 mg.	.02 mg.
Niacin	1.3 mg.	2.4 mg.

NUTRIENT	1 2 OZ. SLICE LUNCHEON MEAT	1 3 OZ. SLICE CHICKEN
Calories	165	115
Protein	8 grams	20 grams
Fat	14 grams	3 grams
Carbohydrate	1 gram	0
Calcium	5 mg.	8 mg.
Iron	1.2 mg.	1.4 mg.
Vitamin A	------	80 I.U.
Thiamine	.18 mg.	.05 mg.
Riboflavin	.12 mg.	.16 mg.
Niacin	1.6 mg.	7.4 mg.

One slice of bologna yields 3.3 grams of protein - Chicken 20 grams of protein.

Remember always to compute cost in relation to nutritive return.

The sodium content of 1 can of commercial soup ranges from 326 mg. to 427 mg. of sodium.

The nutrient, protein, is the one of greatest world wide concern. This is also true in the United States.

Hungry children cannot learn; malnourished children do not grow or develop; and they are less capable of learning.

By comparing the achievements and evaluating the potential of infants and children stunted by severe and prolonged malnutrition with the counterparts who have been free of periods of privation, much is being learned which will be of immense value to this affluent society. These studies show that there are very critical periods in the life of the infant and the preschool child when both mental and physical development can suffer

irreversible stunting. It is presently assumed that the critical period for mental development is from the last trimester of fetal development through the first 2-4 years of life. It is during this time that the brain grows most rapidly and is most sensitive to privation by malnutrition. The human brain, at this time, is growing at the rate of 1 to 2 milligrams per minute. It is also known that prolonged setbacks during these formative years will not be made up during later growth spurts. It is a thesis then, that genetic potential can never be realized when growth and brain development were inhibited in early periods of life.

The poorly fed school child may suffer from reduced educability because of fatigue and lassitude due to improper eating habits. Although complex environmental factors in this country make it difficult to isolate the role of nutrition, there is evidence that malnutrition exerts an effect in retarding mental development. When I try to ascertain some insight into this area, I find that the specific contribution of nutrition and social stimulation also become inextricably intertwined. I know that life takes precedence over growth and development. Thus, children live and look pretty well but may never realize their full potential if malnourishment is in evidence through these formative years. It is very easy to show a relationship between a culture of poverty and a deficient intellectual learning development but it is very difficult to prove the causal nature of it. On the basis of present knowledge it would be unwise of me to state that improved nutritional status alone would improve intellectual learning and development, but I do feel secure in saying that nutrition is a major factor in determining whether an individual gets where his genes say he can go.

*Show three transparencies related to this generalization and show pamphlet

"Nutritional and Intellectual Growth in Children" from the Association for Childhood Education International

3615 Wisconsin Avenue, N.W.

Washington, D.C. 20016

MANPOWER DISTRIBUTION AND PRODUCTIVITY POTENTIAL

	Developed Nations	Developing Nations
Life Expectancy	70 years	35 years
Productive Years	50 years	20 years
Per Cent Under 14 years	20	50
Per Cent Deaths under 5	5	50

'Bordens' Review of Nutrition Research Vol. 26, No. 1 Jan-Mar '65

Vitamin deficiencies that can produce abnormalities of nerve cell metabolism and function.

Thiamin	Pyridoxin
Riboflavin	Cyanocobalamine
Niacin	Ascorbic Acid
Pantothenic	

'Bordens' Review of Nutrition Research. Vol. 26, No. 1, Jan-Mar '65

MENTAL RETARDATION AND ITS RELATIONSHIP TO INBORN ERRORS

1. Disorders directly affect the central nervous system.

2. Protein deficiency may produce serious defects in the brain (low performance).

3. Each disorder causes a different biochemical deviation.

4. The changes in the biochemical environment of the developing nerve cells will result in nerve damage, if intreated.

5. Nerve cell nutrient metabolism is deranged and mental retardation can result.

Advances in nutritional well being must come from individuals doing for themselves, rather than from authoritative control.

I have mentioned before the role of personal values in making decisions. Nutrition education can influence these values.

Let me ask you the following questions:

What brands of margarine contain Vitamin D?

What kind of fat is in synthetic sour cream?

What kind of cereals do you eat for breakfast?

What kind of toothpaste do you use?

Do you use margarine in place of butter because you assume it has fewer calaries?

Do you use iodized salt?

What is your feeling related to cyclamates?

What is your reaction to mercury content of food?

There are hundreds of these types of questions that would explain this generalization.

Let me go back over these questions and ascertain what government controls are involved:

There is proposed legislation regulating the labeling of foods as to

their fatty acid content. Will you know what this means if it is printed on the label? Will you care when you are making a purchasing decision?

Nutrition education is a process -- a process which is concerned with behavior. It is concerned with what people do and not with the knowledge they have in nutrition.

Learning means change - if needed. To be informed may not be to have learned.

Example: fruit drinks vs. fruit juice

You, as a teacher, must believe in nutrition; you must have sufficient background knowledge to be the basis for reasoning and analysis.

Example: "Geritol ad"

This kind of learning is a continuing process between a person and his environment.

Conclusion:

A teacher who is educated in the principles of nutrition education is an investment in the future.

1. Teachers educated in nutrition recognize children in their classroom who evidence nutritional needs.

2. Teachers educated in nutrition can present nutritional fact without superstition, fallacy, or misinformation.

3. Teachers educated in nutrition develop confidence in using nutrition in the classroom because they believe in it themselves.

4. Can you say to yourself:

   I want to eat well

   I know how to eat properly

   I do eat properly

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HOME ECONOMICS CONTRIBUTIONS TO HEALTH EDUCATION FOR MENTALLY HANDICAPPED CHILDREN

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I am privileged to have the opportunity to participate in this Special Studies Institute, Health for the Mentally Handicapped. First, because health education is a vital part of the curriculum, and a total school effort is needed to provide appropriate health experiences for all students which will enable them to cope with their health needs in the best way. Secondly, because the home economics teacher is one of many individuals in a school district who can contribute to health education for mentally handicapped students.

Before focusing specifically on the contributions of home economics education to health education, I'd like to set the scene which serves as a backdrop for the home economics involvement, especially as it relates to the mentally handicapped.

All youth should have the opportunity to develop to their fullest potential, to acquire the basic skills needed to become self-reliant, useful individuals and citizens. Home economics learning situations often provide a secure friendly atmosphere in which all pupils can develop in spite of handicaps or disadvantages. It has been found that such an atmosphere has been conducive to learning for mentally handicapped youth who often find themselves on the fringe of many "taken-for-granted" experiences. Home economics education continues to contribute to broadening the horizons of that segment of the population frequently viewed as academic outcasts.

Some ways in which the home economics teacher is involved in working with mentally handicapped students are:

1. Teaching students who may be scheduled in a class by themselves or integrated in regular home economic classes.

2. Serving as consultant or resource person to the special class teacher.

3. Participating as a member of a team to help with such aspects as planning curriculum, analyzing accomplishments and potential of students.

4. Organizing a chapter of Future Homemakers of America and encouraging mentally handicapped students to participate.

5. Providing guidance to students individually or in groups in such areas as standards of behavior and dress, aspirations for jobs or careers in the field of home economics.

6. Serving as an advisor to one or more students to help students feel they have someone who knows them and is concerned about them.

This type of involvement is paramount to the achievement of the overall goal of home economics education which is:

> to assist family members of all ages to develop attitudes, appreciations, understandings and abilities for the achievements of satisfying personal, family, and community life.

To implement this goal in New York State, the Statewide program of home economics education embraces two program aspects, with concern for contributing to the total education of all individuals--who represent the span of abilities, background, and age levels comprising the population of today.

The two program aspects of home economics, Preparation for Personal and Family Living and Preparation for Employment, encompass eight areas of learning: family relationships; home management; family economics; clothing and textiles; family and community health and safety; child care and development food and nutrition; housing, equipment and furnishings. As one of the eight areas of learning, family and community health and safety has been given great visibility in the home economics curriculum. Recognition of the impact

of health on all other aspects of living and working is reflected in the health emphases included in each home economics course. A one-semester general home economics course for students in grades 11 and 12 entirely devoted to indepth study of health concepts. Home economics occupational courses stress the relationships of good health to qualifications for employment, and some job competencies focus on safeguarding the health of others.

The content of each course in the State home economics program and the program of work for Future Homemakers of America, the home economics youth organization, have been analyzed in relation to health and health-related concepts, using the five-strand approach. This analysis is available in chart form to assist home economics teachers and other local personnel in capitalizing on home economics learnings as a part of total health education planning.

I'd like now to focus on the contributions of home economics education to health education. At the State level, the Bureau of Home Economics Education and the Bureau of Health Education considered the mutual concerns of home economics and health educators for the improvement of health practices of individuals and families. The outcome was the development of a joint statement which outlines some ways in which interdepartmental cooperation can be accomplished. The joint statement is expected to be distributed shortly. I shall quote the beginning paragraph:

> The need for giving more attention to health education is evidenced by the serious health problems which face our society today. These problems affect both young and old. Therefore, health education must begin early in life, and formally, early in the school years. Instruction should aim to affect both the individual's behavior and his attitudes as well as increase his understanding of health information.

Interaction between the health and home economics programs will vary as determined by local needs and available human and material resources. However, it is quite clear that the health challenge can be most successfully met only if all of the available resources are brought into play. Each can bring a concentration of effort where it can be most effective. Some suggested ways home economics educators can be involved in the development of the health education program include:

1. Setting overall goals to help meet the health needs of students.
2. Serving on district curriculum committees for planning health education programs.
3. Planning team-teaching approaches or teacher exchanges where applicable.
4. Sharing of successful experiences and material resources.
5. Developing cooperatively pre-tests or other appropriate evaluative materials.
6. Participating in joint inservice teacher training programs.
7. Undertaking joint research activities.

Because the basic mandated health education program should establish foundations for students to pursue further study and action regarding essential health areas, the contributions of home economics education extends beyond the developmental stage. Indepth study in some of the health areas such as nutrition, personal health practices, disease control, safety and accident prevention, sociological health problems, mental health environmental pollution, control and consumer health may be provided through selected home economics courses. For example, HE 3, Personal and Family Relationships; HE 4, Child Development; HE 5, Family and Community Health; HE 10, Nutrition and Meal Management; HE 12, Family Values for Democratic Living. Use of the home economics department also permits students to engage in related laboratory

experiences.

Home economics teachers can use their specialization to supplement and enrich the health curriculum through cooperative endeavors such as:

1. Serving as a consultant to teachers, administrators, and students regarding specific health areas.

2. Reinforcing specific health concepts in home economics classes through varied application experiences such as preparing food, showing location of safety hazards in the home; participating in meetings to learn about social concerns in the community; practicing good walking sitting and lifting posture; displaying shoes of different styles and types of materials; demonstrating procedures for manicures and pedicures.

3. Planning cooperatively for out-of-school experiences such as field trips to social service agencies, community organizations, supermarkets, health clinics.

4. Using Future Homemakers of America, the home economics youth organization as a means of enriching and extending classroom health learnings through individual and group projects.

The contributions of home economics education to health education for mentally handicapped students is underlined by the fact that the young people we encounter in our classrooms are infinitely more significant than the subject matter scheduled for teaching. In the school environment not only are students exposed to subject matter but they also learn how to feel about themselves and others and how to seek answers. Answers to questions such as those proposed by Arthur Miller, the playwright:

> How may a man make of the outside world a home? How and in what ways must he struggle, what must he strive to change and overcome within himself, and outside himself if he is to find the safety, the surroundings of love, the ease of soul, the sense of identity and honor, which all men have connected in their memories with the idea of family.

That is what the emphases in the cooperative efforts of home economics and health education are all about. Each instructional area contributing to the other can help the mentally handicapped to discover how and in what

ways he can grow to establish an independent adult life; what he must accept and what he can change - within himself and outside himself to find health, safety, love, identity and honor. Our continuing challenge is to provide learning experiences which will help mentally handicapped youth to develop attitudes, appreciations, understandings and abilities which contribute to the achievement of healthful living necessary to satisfying personal, family and community life.

Selected Comments from Discussion and Question and Answer Periods

"The mentally retarded are part of the social milieu so we should not keep isolating them. They are part of our society even though some are partially dependent. Colleges training school personnel need to include courses for educating the exceptional child to all teachers."

"One criticism of team teaching is that it really doesn't concentrate on teaching the student but it does on the subject."

"We've had criticism over the Special Olympics because of poor management and supervision. Children participating bear labels that stigmatize and develop poor attitudes because of lack of preparation for competition. Divisions and categories are not clear. Too few children really participate and less get glamour. A physical fitness program should be part of education for all and not something to be obtained from fund raising schemes for aren't the MR children part of total school society. Include all children in field events and limit competition within the MR's limitations, capacity, and safety."

"Belonging is important to all children and that includes the mentally retarded who do not fully understand so must be taught to resist alcohol and drinks and temptations from peer group. Their feelings and desires are the same as normal children is but they are confused. There is multistimulation in environment that adds to confusion. Parents and peers help in their poor self concept which is often reenforced by an unaccepting and unfeeling teacher."

"Rapport is vital."

"Sex education is taboo in many school districts yet statistics should be a real concern as to numbers of pregnant MR girls. We need more of, not less!"

"No one health curriculum and/or guideline will serve for all children or someone elses guide may not fit your needs."

Re: Mental Health -- "BOCES problems are many and help rejection of child in such attitudes. We don't have to take these kinds for this or that as you're a BOCES class. Sending child away from home district tells him 'you're not part of us.'"

Re: Drugs -- "Know your drugs, keep up with research, truly represent your life-style as students spot and test phonies even in teachers."

"There is a tremendous lack of physical fitness programs for mentally retarded. They need it more and yet are scheduled less."

Lively discussion followed presentation of role of nurse. She is not a certified teacher but a mandated service - a curious logic. Participants were critical as this role was not evident in many situations. Often nurses were too busy for MR's or knew less about them than the teachers working with them. There was agreement that the nurse could do more with parent education, agency cooperation and instruction.

Teacher Discussions

In the teacher exchange and sharing of ideas many suggestions of tried materials we made - both commercial (posters, placemats, records and songs, workbooks among a few) and teacher-made. For teacher use background books such as "Movement Exploration and Games for the Mentally Retarded" by L. C. Hackett (Peek Pub.), "A health - Centered Core Curriculum for Educationally Handicapped Children" by B.A. Taylor and C. Sherrill (Peek Pub.), "Plans for Living-Health and Safety" by M. Hudson and A. Weaver (Fearon) were mentioned.

EVALUATION FORMS

Wednesday, May 12, 1971

Session on Sociological and Environmental Aspects of Health Education

Evaluate the 14 Computer Units in terms of their general content and in terms of their specific application to classroom use in special classes for the mentally handicapped.

Session on Personal and Physical Health Aspects of Health Education

Identify the most helpful items in this interchange session of ideas, methods, and techniques.

Did you find any of them of immediate practical use for implementation in your program?

Please identify these.

Session on Community Assistance in Health Education and Reeducation.

Identify the most valuable aspects of this presentation as to background information of resources and what they contribute to your overall knowledge in the field of drugs, predelinquency, and recreational activities.

Thursday, May 13, 1971

Identify the most valuable aspects of this session to you as to content, material, variety of techniques and methods, practicality, and stimulation for your thinking. Make any other comments and suggestions you wish.

Session on Health Education

Session on Health in Relation to Physical Fitness, Rest, Exercise, and Recreation.

Friday, May 14, 1971

Session on Implementation of the New York State Health Strands Curriculum in Special Education

Identify the most valuable aspects of this session in terms of background information, adaptability, usefulness to you and its immediate application for classroom procedure. Did you feel it gave you assistance in working cooperatively with nurse-teacher and other health personnel?

Did it cover prevention, safety, first-aid, dental health, sensory education, etc., covered in some of the strands?

Identify other areas.

Session on Health in Relation to Nutrition.

What aspects of this session helped you in area of nutrition for background and immediate application and for assistance from another school specialist?

Friday, May 14, 1971

General Evaluation of Institute:

Evaluate the total institute in terms of:

Content

Organization of material

Appropriateness to Health Education

Practicability to Classroom Instruction

Variety

Materials and Displays

Communication (meeting resource people and having opportunity for interchange)

List your suggestions how to further improve in service training institutes in this area:

EVALUATION

General Reactions

Wednesday, May 12, 1971

Session on Sociological and Environmental Aspects of Health Curriculum

General philosophy back of units is sound and content will allow for flexibility so good starting point.

Value of this session to be seen when units are developed and put to use.

Not too convincing yet as actual health units weren't available.

Demonstration well presented and enthusiastic but not too helpful in actual health content. Too much stress was on computer aspect rather than health. Tremendous, new, and fantastic idea to two new health teachers. Old hat to many special educators.

Units could provide individualization of instruction.

Potential for 14 unit teaching program promising -

General overall reaction - "good for EMR'S, not useful for TMR'S and fantastic idea for regular health classes."

Session on Personal and Physical Aspects

Sorry more time wasn't available to this session.

Good curriculum ideas from teachers.

Practical Session with helpful ideas

Examples cited - obstacle courses, mazes, use of fleece balls, suprise games for trainables, ideas to relieve steam and tension, use of soft background music records and tapes, use of sensory-kinesthetic materials, use of models, dancing (folk and square) rhythms.

In drug education stress mental health rather than teaching physiological facts. Integrate with other areas of curriculum. Involve students in evaluating materials.

Session on Community Assistance in Health Education and Reeducation

Panel rated mostly excellent to good with one fair opinion.

All three speakers gave informative and excellent presentations from their fields and new insights to troubled youngsters. Slides and talk on recreation gave good ideas for use of environment (camping, trips, walks, enrichment through use of library facilities for retarded adults).

New techniques were sampled through monologues, role playing, rap sessions, councils.

Reenforced findings on drugs, council research, importance of personality of teacher/leader, and need for correcting misinformation.

Thursday, May 13, 1971

Session on Health Education

Excellent to good background for health teaching.

Interesting and good stimulation.

Suggestions were practical and realistic for classroom use.

Suggested readings were good.

Good, enjoyable, honest, sincere, and humble speaker.

Review but well worth hearing.

Inspired the "new" to old problems. Ex. Contamination and inhalation.

Rebash of Kirk and Johnson.

Well organized session - impressive and informative.

Stirred up from stagnation into less fragmentation of affairs. Enthusiasm is needed to stir up and convince school committees and Boards of Education.

Gave new approach to alcohol use.

Guidelines, curriculum guides, and strands can be adjusted to fit even the more intellectually limited child.

Need for sex education for MR's because of their susceptibility and overt drives.

Session on Physical Fitness, Rest, Exercise, and Recreation

Outstanding to very good session - well organized with excellent demonstration, movie, and three very helpful distributions. "Loved this one! and went out motivated"

"Rewarding and satisfying session"

Applicable to young EMR's and TMR's.

Derived many helpful suggestions - Good to see visual - motor - perceptual activities.

Comprehensive and adaptable to Special Education and for designing a physical education program.

Pointed to seed of development levels in progressing from simple skills to more difficult ones.

Circuit approach and idea of "overload" was completely new to three participants.

Covered fun, balance, rest, and exercise for health.

Most helpful and interesting presentation.

General Comments for Thursday Sessions

Entire day was very good! Too bad more physical education teachers working with MR's were not present!

Both speakers better prepared in their fields than any institute attended.

Both did outstanding job of bringing their field to participants.

Excellent to very good.

Informative and stimulating and down-to-earth with new ideas and new techniques for student activities.

Health education to MR's differs in degree but needs coordinated effort of special educators and physical education teachers - There is a need for creativity to put material and instruction across. Certification does not constitute a good teacher but willingness and dedication helps. There is a need for continuing evaluation of teachers. Warm accepting teachers for MR's can stimulate. Qualities of health teacher can make or break a health program.

Parents should be involved for reenforcement.

Suggestions, materials, recommendations all rated very good.

"Very impressed with total day and truth in institute theme 'Happiness Is Healthiness' for life is health."

"You don't sit to be fit"

Friday, May 14, 1971

Session on Implementation of Health Strands
Curriculum in Special Education

Good overview of nurse-teacher role and need for multi-discipline evaluation.

Should do more parent counseling.

Strands presentation interesting and informative and led into many problems.-

Good background and opportunity to peruse strands in exhibits.

Stressed team planning and service to all children - united approach.

Excellently drew out lively discussion - wish it could have been taped.

Interesting audience reaction. There are problems in PPS services

Content excellent and pointed up need for interdisciplinary approach.

Audience reaction gave indication nurse-teacher often knows less of handicapped child than special education teacher - Too often lip service is given and concentration is on paper work and regular classes. Support for full time nurses was expressed.

Handicapped Committee and how it functions and its role.

Was new to many - At least one school nurse will become part of it on return to her district.

BOCES - Audience felt nurse should be part of this effort as she is not certified teacher.

Cooperative attitude of professionals present was excellent and team work was emphasized but not yet working everywhere - Problem of personalities and lack of cooperation among specialists in all areas of education and "too busy for special students" - Problems of relationships among disciplines were identified and understanding of differences in programs and problems of BOCES as opposed to cities was gained.

Friday, May 14, 1971

Session Health in Relation to Nutrition

Excellent presentation and discussion - Stimulating, Excellent background, and well organized - Content just great! Enlightening! Relevant. Reenforced - Good review brought down to earth and on personal level - "A terrific refresher course - a dull subject brought alive." For three people too technical for classroom applicability - Good suggestions for future planning - Home Economics usually gives lip service and is too philosophical. Not too helpful or related - Only few concrete examples for EMR's - Home Economics teachers should assume more responsibility.

General Evaluation of Total Institute

Content

Outstanding; terrific, excellent, very good, good, very meaningful, and only one fair. Timely. Covered wide - range of resources and areas of health - Good cross section of all health areas.

Organization of Material

Excellent organization and continuity

Exceptionally well - organized to very good to good

Question - Answer periods were very good

Meaningful

Appropriateness to Health Education

Very good

Good coverage of subject and newer techniques

Very appropriated for health teaching

Very worthwhile experience

Most satisfactory

Reenforced ideas and motivated to use the new

Practicability to Classroom Instruction

Very Good to Good to Very Practicable to (3) Fair to

All could apply and some need to be adapted but, all could be used in some situation

CBRU - least practical -

Home Economics and Nurse-teacher presentation least helpful -

Variety

Excellent - Very Good - Good - Included speakers, films, slides, transparencies, demonstrations, dialogue, monologues, discussion, and panels.

Varied and yet related

All speakers had fresh approach and new challenge

Materials, Exhibits and Displays

Very helpful and appropriate

Excellent to Very Good in getting new ideas

Communication

"Most satisfying total experience"

Very good interchange of opinions and ideas

Ample time for sessions and meals

Excellent discussion in post presentation to overall very good to good group dynamics

enjoyed question - answer period

Good social interchange during coffee breaks and lunch with speakers

Much interpersonal relationships and enthusiasm from speakers

All institute leaders most gracious and available and dedicated people and a pleasure to be with.

Plan an interdisciplinary workshop or institute by interdisciplines

at SUNY, Albany. Include administrators of Special Education programs and of schools where BOCES are located, physical education teachers, psychologists, nurses, special education teachers, and home economics teachers. Request more BOCES administrators be present. Various staff do not understand their role in and responsibility for handicapped children and schedule these children last.

Plan such a health institute for all special education areas -

Expressed concern over cuts for rehabilitation

Include more small group discussions

Include more demonstrations as in Thursday's presentation

Include more on mental health (1)

Exhibit original health materials of teachers and children

Include students or students on a panel -

Arrange visitation to MR classrooms

"Most satisfying institute - Have more of this kind"

Use some meal times for discussions and sharing

"A rich and full institute"

Develop CBR Units on jobs, marriage, and child care and continue one on movigenics. Simplify one on sex

State Education Department set up health pilot program for EMR's education and home economics for decade ahead. Provide inservice to retrain many currently in field.